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JOSEPH SINNAPPAN v. PP

HIGH COURT MALAYA, IPOH
ABDUL WAHAB MOHAMED J
[CRIMINAL APPEAL NO: AA-42(Ors)-5-07-2023]
9 OCTOBER 2024

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Abstract – *Section 337 of the Criminal Procedure Code serves as the terms of reference within which the Coroner conducts the inquest into the death of the deceased. As such, the Coroner cannot act outside the perimeter of the said terms of reference. In an inquest, there are no parties, indictment, prosecution, defence and trial. It is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation which is quite unlike a trial, where the prosecutor accuses and the accused defends, while the judge holds the balance or the ring, whichever metaphor one chooses to use.*

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CRIMINAL PROCEDURE: *Inquest – Inquiry into death – Appeal against decision of Coroner delivering 'open verdict' – Inquiry into death of trainee cadet undergoing Royal Malaysian Navy Trainee Cadet Officer Training – Post-mortem concluded cause of death as pulmonary oedema – Whether post-mortem conducted by trained forensic pathologist – Whether medical officer report provided sufficient explanation on cause of death – Whether cause of pulmonary oedema found – Whether cause of death consistent with leptospirosis – Whether supported by evidence and witnesses – Whether findings of 'open verdict' supported by evidence – Whether ought to be set aside – Criminal Procedure Code, ss. 328 & 337*

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This was an appeal against the decision of the Coroner who delivered an 'open verdict' in the inquest of the deceased, who was undergoing the Royal Malaysian Navy Trainee Cadet Officer Training. On 19 May 2018, the deceased took part in a supervised physical training, whereby the deceased informed one of the Navy Officer on duty that he was unable to continue with the training as he felt tired, weak and had difficulty in breathing. Hence, he was pulled aside and instructed to undergo light training by himself. Later, when all the trainee cadet officers were instructed to go back to the hostel, the deceased was found to have spilled while showering, in a weak state. He was brought to the Hospital Angkatan Tentera, where he was pronounced dead. A post-mortem conducted by the medical officer ('SI-1') at the hospital concluded that the cause of death was pulmonary oedema. The thrust of the appellant's appeal was that the cause of death was pulmonary oedema caused by leptospirosis, the Royal Malaysian Navy ('TLDM') officers had denied the deceased to report sick to acquire medical examination and treatment and the act of denying the deceased to report sick barred the deceased from getting treatment which ultimately led to his death. The issue for the court's determination was whether the 'open verdict' by the Coroner may be sustained.

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Held (setting aside findings of 'open verdict' of Coroner and substituting it with homicide):

(1) An inquiry of death is a fact-finding process by the Coroner to see if the provisions of, *inter alia*, ss. 328 and 337 of the Criminal Procedure Code ('CPC') have been complied with. The sole objective of an inquiry is to determine whether any person is criminally concerned in the cause of death. An inquiry of death is not like a criminal trial. The procedure and rules of evidence which are suitable for the accusatorial process are unsuitable for an inquiry of death which essentially is an inquisitorial process. At the close of an inquiry there is no finding of guilt, conviction or punishment of anyone. The threshold for the standard of proof in an inquiry of death must thus be lower than that for a criminal trial. Therefore, the degree of determination by the Coroner in an inquiry of death is merely to find out who may or may not be concerned or involved in the cause of death. It is for the police to investigate further to find out who is criminally liable or responsible in the cause of death and it is for the Public Prosecutor to decide whether to charge anyone for an offence of homicide if sufficient evidence has been uncovered and thereafter, to secure a conviction based on the evidence. The court, in order to return an 'open verdict', must see whether: (i) there are proved facts; and (ii) the proved facts are enough on the balance of probabilities to satisfy other conclusion(s). When there is insufficient evidence to bring in any of the other verdicts, only then must an open verdict be adverted to. (paras 25, 26, 29, 31 & 32)

(2) The post-mortem should have been conducted by a trained forensic pathologist. Herein, the post-mortem was conducted by SI-1, who was not an expert forensic pathologist, but only a medical officer and the report concluded the cause of death to be pulmonary oedema. There was no explanation on how the deceased, a healthy individual, could have suddenly died of pulmonary oedema. A later supplementary post-mortem was issued stating that there were features of lung infection found. Yet, it failed to identify the source of infection, and the cause of death remained to be pulmonary oedema. (paras 46-48)

(3) Pulmonary oedema alone, as the cause of death, was insufficient as it did not explain how it occurred. On the other hand, the cause of death being consistent with leptospirosis was supported by the evidence of SI-30, a renowned forensic pathologist with experience in the field, upon examination of all available documents relating to the post-mortem, the medical history of the deceased, and the 'Ulasan Pegawai Kesihatan Daerah Manjung', 'Laporan Kejadian Kluster Acute Respiratory Syndrome Probably Secondary to Leptospirosis', all of which served to prove his conclusion to the cause of death. The evidence of SI-30 as an

A expert must be given due weight and this court accepted the findings of SI-30 and stated the cause of the death was pulmonary oedema caused by leptospirosis. (paras 48, 51, 52, 54, 55 & 58)

(4) The two 'lapor sakit' sheets directly contradicted any evidence that the deceased did not attempt to seek medical treatment. It corroborated the B testimony that there was a denial of treatment of the deceased, as attested to by SI-24, SI-25 and SI-27, the witnesses who agreed that the deceased was having difficulty in completing physical training, which pointed to a deteriorating physical state. There were no reasonable grounds given by the Coroner as to why she preferred and accepted the testimonies C stating that the deceased did not seek treatment over the testimonies of SI-24, SI-25 and SI-27 and the two 'lapor sakit' sheets. Therefore, the death of the deceased was caused by leptospirosis which went untreated because of the unlawful refusal by TLDM officer to allow him to seek medical treatment. (paras 62, 64 & 66)

D **(5)** The findings of the 'open verdict' of the Coroner was therefore, set aside and substituted with 'homicide', that the cause of death of the deceased was pulmonary oedema caused by leptospirosis, and that his untimely death was a direct consequence of the TLDM officers in charge of the cadet training in denying the deceased to seek medical treatment E pursuant to para. (d) of the Practice Direction of the Chief Justice No 2 of 2019 and pursuant to s. 337 of the CPC to decide who was the person criminally concerned in the cause of death. (para 67)

Case(s) referred to:

F *Dr Lo Sook Ling Adela v. Au Mei Yin Christina & Anor [2002] 1 SLR 408* ***(refd)***
In Re Anthony Chang Kim Fook, Deceased [2007] 2 CLJ 362 HC ***(refd)***
In Re Inquest Into The Death Of Sujatha Krishnan, Deceased [2009] 5 CLJ 783 ***(refd)***
ING Insurance Bhd v. Rathinasamy Kasinathan [2018] 10 CLJ 488 CA ***(refd)***
Majuikan Sdn Bhd v. Barclays Bank Plc [2014] 9 CLJ 337 CA ***(refd)***
PP v. Seeralan Suppiah [1985] 1 CLJ 524; [1985] CLJ (Rep) 250 SC ***(refd)***
G *PP v. Shanmugam & Ors [2002] CLJU 160; [2002] 1 LNS 160 HC* ***(refd)***
R (Ahmed) v. South and East Cumbria Coroner [2009] EWHC 1653 ***(refd)***
R v. South London Coroner; ex parte Thompson [1982] 126 SJ 625 ***(refd)***
Re Rumie Mahlie, Deceased [2007] 10 CLJ 697 HC ***(refd)***
Teoh Meng Kee v. PP [2014] 7 CLJ 1034 CA ***(refd)***

Legislation referred to:

H Criminal Procedure Code, ss. 328, 337

For the respondent - AG's Chambers
For the appellant - M/s Daim & Gamany

[Editor's note: Appeal from Sessions Court 2; Criminal Case No: AA-65A-4-05-2019.]

I *Reported by S Barathi*

JUDGMENT

Abdul Wahab Mohamed J:

Introduction

[1] This is an appeal on the decision of the Coroner made on 16 June 2023 ("appeal"). This criminal appeal was filed on 30 June 2023 by the appellant's counsel, M/s Daim & Gamany ("counsel").

[2] The appellant is the father of one Soosaimanickam a/l Joseph, the deceased who was declared dead on 19 May 2018.

[3] The appellant here appealed against the decision of the Coroner in delivering an "open verdict" in the inquest of the deceased.

Background Facts

[4] The deceased was a trainee cadet officer who was undergoing the Royal Malaysian Navy Trainee Cadet Officer Training (hereafter referred to as his "cadet training") at KD Sultan Idris 1 ("KDSI 1") that began on 12 May 2018

[5] A week after he started his cadet training, on 19 May 2018 was declared dead by the Hospital Angkatan Tentera (hereafter referred to as "HAT") at 1.45pm.

[6] On 19 May 2018, the deceased took part in a supervised physical training, whereby the deceased informed one of the navy officers on duty that he was unable to continue with the training because he feels tired, weak and had difficulty breathing, hence, he was pulled aside and instructed to undergo light training by himself.

[7] Afterwards, all the trainee cadet officers were instructed to go back to the hostel where the deceased was found to have spilled while showering, in a weak state. He was loaded into a car and brought to HAT, and was pronounced dead at 1.45pm.

[8] A post-mortem was conducted by medical officer Dr Saravanan Suppiayah at the Seri Manjung Hospital on 20 May 2018 where it was concluded that the cause of death was pulmonary oedema.

[9] The issues that give rise to this appeal is with regard to the Coroner's determination regarding the cause of death and the manner by which the deceased passed away, which is directly linked to the conclusion of the criminality involved in the death of the deceased.

[10] The thrust of the appellant's appeal is that the cause of death is pulmonary oedema caused by Leptospirosis, the Malaysian Royal Navy ("TLDM") officers have denied the deceased to report sick to acquire medical examination and treatment and the act of denying the deceased to report sick barred the deceased from getting treatment which ultimately led to his death.

A **The Law Governs An Inquest Proceeding**

[11] In Malaysia, inquests are referred to as inquiries of death and they are governed by Part VIII, Chapter XXXII of the Criminal Procedure Code and Practice Direction of the Chief Justice No. 2 of 2019.

B **[12]** The major task of the Coroner is to investigate a "cause of death". Section 328 of the CPC stated:

> In this Chapter the words "cause of death" include not only the apparent cause of death as ascertainable by inspection or post-mortem examination of the body of the deceased, but also all matters necessary to enable an
C opinion to be formed as to the manner in which the deceased came by his death and as to whether his death resulted in any way from, or was accelerated by, any unlawful act or omission on the part of any other person.

[13] Due to this effect, s. 337 of the Criminal Procedure Code ("CPC") further stated that:
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> A Magistrate holding an inquiry shall inquire when, where, how and after what manner the deceased came by his death and also whether any person is criminally concerned in the cause of the death.

[14] In other words, pursuant to s. 337 of the Criminal Procedure Code,
E the terms of the inquiry are as follows:

(i) when the deceased died?

(ii) where the deceased died?

(iii) how the deceased died?
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(iv) on what manner the deceased came by his death?

(v) whether any person is criminally liable in the cause of the death of the deceased?

[15] Sulong Matjeraie J (as he then was) in *In Re Anthony Chang Kim Fook, Deceased* [2007] 2 CLJ 362 where he had this to say:
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> [7] Section 337 of the CPC serves as the terms of reference within which the Coroner conducts the inquest into the death of the deceased. As such the Coroner cannot act outside the perimeter of the said terms of reference.
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> [8] It must be borne in mind that in an inquest, there are no parties, there is no indictment, there is no prosecution, there is no defence and there is no trial. It is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the
I ring, whichever metaphor one chooses to use, see *R v. South London Coroner; ex parte Thompson* [1982] 126 SJ 625 DC.

[16] Therefore, it is all about fact-finding proceedings with a very limited jurisdiction. In discharging the above-said duty, a judge is free from the constraints of the normal rules of procedure and evidence which apply in the accusatorial/adversarial process.

[17] Section 337 of the CPC serves as the terms of reference within which the Coroner conducts the inquest into the death of the deceased. As such, the Coroner cannot act outside the perimeter of the said terms of reference. It must be borne in mind that in an inquest, there are no parties, there is no indictment, there is no prosecution, there is no defence and there is no trial. It is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use, see *R v. South London Coroner; ex parte Thompson* [1982] 126 SJ 625 DC.

[18] The said position was discussed by Suriyadi Halim Omar J (as he then was) in *PP v. Shanmugam & Ors* [2002] CLJU 160; [2002] 1 LNS 160 in the following words:

> To arrive at a correct conclusion, it is essential that I resolve a specific preliminary issue first *ie*, whether a magistrate who conducts such an inquiry under discussion, is bound by the normal rule of evidence. I will begin by stating that in a gist, due to the various amendments to the Criminal Procedure Code (Amendment) Act, the Courts Act 1948, the Courts (Amendment) Act 1950 and finally the substantive FMS Criminal Procedure Code being amended by Act 324/76 making it applicable to the whole of Malaysia, and repealing all the other statutes governing inquests or death inquiries, the Magistrate Court now has assumed the powers and duties of a Coroner Court. It had always been accepted that a Coroner's inquest was a court of law, though not a court of justice, as it was essentially set up to investigate and ascertain the cause of death. Apart from being shackled by a limited mandate, a Coroner was also not bound to follow the usual procedure of law courts. With the above mentioned statutory amendments, the position of a magistrate now is no different to the archaic Coroner when holding an inquiry of death, and thus similarly not bound by the usual procedure of courts of law. *In Re Loh Kah Kheng (Deceased)* (*supra*) Mohamed Dzaiddin J (as His Lordship then was) when reviewing an inquiry had in crystal clear terms remarked:
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> > I am, therefore of the opinion that so long as the learned magistrate was satisfied that there was evidence, in whatever form or manner elicited and whether admissible or not, which could assist her in establishing the cause of death of the deceased, she was perfectly entitled to know and take cognisance of it.
>
> Under held of the above case, is also authored:
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> > The function of a magistrate in holding an inquiry of death is to inquire, *inter alia*, whether any person is criminally concerned in the cause of death. The inquiry is to be held by examining witnesses

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> on oath and the magistrate may admit any evidence which he thinks fit, especially hearsay evidence. His duty is to ascertain the cause of death and he is not bound to follow usual procedure.

In spite of that clear enunciation, in that a magistrate is not bound by the usual procedure, the eventual verdict is a different story. A magistrate
B who conducts an inquiry must confine himself to the evidence made available to him, and at the end of the day decide on that evidence alone (*Richard Evans & Co Ltd v. Astley* [1911] AC 674). Guesswork is certainly out. If any verdict is based on probability and not on the established facts that verdict must certainly be quashed and an open verdict returned.

C **[19]** The above-said principles are also outlined in the practice direction of the Chief Justice No. 2 of 2019 with some additional points that, *inter alia*, the Coroner/Magistrate must, at the conclusion of the inquiry, deliver a verdict on any one of the following:

(i) an open verdict (mati yang tidak dapat ditentukan cara kematian);

D (ii) misadventure (mati akibat kemalangan);

(iii) natural death (mati akibat penyakit);

(iv) homicide (mati akibat perbuatan orang lain); or

(v) suicide (mati akibat perbuatan sendiri).
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[20] It is trite that a Coroner is not required to call every witness who might have relevant evidence, but sufficient witnesses to undertake a proper inquiry (see *R (Ahmed) v. South And East Cumbria Coroner* [2009] EWHC 1653).

F **Standard Of Proof**

[21] Standard of proof to which a Coroner is to apply on inquest cases are on "balance of probabilities". The test of balance of probabilities is a significantly lower standard of proof. However, this cannot be mere speculation, but should be some specific evidence upon which the decision
G can be based.

[22] Mah Weng Kwai J (as he then was) in *Teoh Meng Kee v. PP* [2014] 7 CLJ 1034 at p. 1079 para. 111 stated in the following words:

> *It will be noted that s. 328 of the CPC speaks of "opinion". The section does not*
H *stipulate what the standard of proof that has to be applied in an inquiry of death. Although s. 328 of the CPC is silent on the standard of proof, of course, it cannot be said that there is no standards to be applied. That would be an unacceptable position in law. I am of the view that all that is required of the Magistrate is to arrive at an opinion applying the balance of probabilities (civil) standard test on objective basis. There must be sufficient evidence to arrive at an opinion, in particular whether*
I *the death resulted in any way from or was accelerated by any unlawful act or omission on the part of any other person.*
>
> (emphasis added)

[23] In the case of *In Re Inquest Into The Death Of Sujatha Krishnan, Deceased* [2009] 5 CLJ 783 at p. 788, the learned Coroner held that:

> It is important for me to say that the law is silent on the standard of proof to which a Coroner is to apply his mind when dealing with the evidence presented before him. For example, when there are two conflicting evidence on oath, the question of who should the Coroner believes and what test is to be applied is not discussed in the decided cases.
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> His Lordship further relies upon the rational from the local authority of *Public Prosecutor v. Shanmugam* [2002] 1 LNS 160; [2002] 6 MLJ 562 and English case of *R v. Huntbash; ex parte Lockley* [1944] KB 606 and concluded that, "as far as the standard of proof in an inquest is concerned, I am of the view that the test in an inquest is on the balance of probabilities sliding to the beyond reasonable doubt.

[24] Micheal Barnes, State Coroner of Brisbane, Australia in the case of *Inquest into The Death Of Liam Richard Vidler-Cumming* held:

> A Coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the Briginshaw sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

Procedure

[25] An inquiry of death is therefore a fact-finding process by the Coroner to see if the provisions of, *inter alia*, ss. 328 and 337 of the CPC have been complied with. The sole objective of an inquiry is to determine whether any person is criminally concerned in the cause of death.

[26] An inquiry of death is not like a criminal trial. There is no complainant, no prosecutor and there is no accused person on trial. It is only an inquiry by a Coroner as to the cause of death and the Deputy Public Prosecutor is there not to prosecute anyone but only to assist the court with the examination of witnesses for the purpose of receiving the evidence. Hence the officer "conducting" the inquiry is known as an assisting officer and not as a prosecuting officer. The counsel present is there not to defend anyone but only to look after the interest of those who have appointed him. The procedure and rules of evidence which are suitable for the accusatorial process are unsuitable for an inquiry of death which essentially is an inquisitorial process. At the close of an inquiry there is no finding of guilt, conviction or punishment of anyone. The threshold for the standard of proof in an inquiry of death must thus be lower than that for a criminal trial.

[27] In the case of *PP v. Seeralan Suppiah* [1985] 1 CLJ 524; [1985] CLJ (Rep) 250 stated as follows:

> As inquest is not like a trial. There are no parties to prosecute and to defend. It is only an inquiry by a Magistrate as to the cause of death and prosecuting officer is there not to prosecute anyone but only to assist the Court with the examination of witnesses for the purpose of giving evidence. A defence Counsel present at an inquest is not there to defend anyone, but only to look after the interests of those who engage him. Whilst he has no right to speak as of right, this right seldom becomes an issue because the Court normally gives such indulgence whenever it is asked. However, although addressing the Court without permission is not a contempt it is certainly not polite to do so without permission. In polite circles such as the legal profession this simple etiquette is expected.

[28] As noted earlier, s. 337 of the CPC speaks of an inquiry as to whether any person is "criminally concerned in the cause of the death" only. Importantly, the section does not speak of any person who is criminally liable in the cause of the death.

[29] Therefore, the degree of determination by the Coroner in an inquiry of death is merely to find out who may or may not be concerned or involved in the cause of death. It is for the police to investigate further to find out who is criminally liable or responsible in the cause of death and it is for the Public Prosecutor to decide whether to charge anyone for an offence of homicide if sufficient evidence has been uncovered and thereafter to secure a conviction based on the evidence. It is not disputed that the power of a Coroner to inquire does not include the power to determine a penal offence (see *In Re Anthony Chang Kim Fook, Deceased* [2007] 2 CLJ 362).

What Does Open Verdict Mean?

[30] This is what was said by Mohamad Ariff Yusof JCA (as he then was) about "open verdict" in *Teoh Meng Kee v. PP* [2014] 7 CLJ 1034:

> To return an "open verdict" is not a sign of failure; it is a verdict in its own right. We have been referred to a very useful text by Christopher Dorries; *Coroners' Courts - A Guide to Law and Practice* (2nd edn), which deserves quotation for its concise statement of the principles:
>
> > An open verdict is a decision by the Coroner or jury that the evidence 'does not fully or further disclose the means whereby the cause of death arose'. It is a verdict in its own right, indicating that the evidence is insufficient to satisfy any other conclusions. This may arise because, despite the best efforts of an investigation, it is impossible to determine whether a death was intended a suicide or came about by accident. In other cases there may be a suspicion that foul play is involved but no proof to the required level ... (at p. 272 of the text)

[31] This court must see whether firstly there are proved facts, secondly the proved facts are enough on the balance of probabilities to satisfy other conclusion(s) (misadventure, natural death, homicide or suicide).

[32] It is only when there is insufficient evidence to bring in any of the other verdicts, then open verdict must be adverted to. This was emphasised by Suriyadi Halim Omar J (as he then was) in *PP v. Shanmugam & Ors* [2002] CLJU 160; [2002] 1 LNS 160; [2002] 6 MLJ 562 in these words:

> At the conclusion of an inquiry the learned Magistrate may deliver the finding of death by misadventure (caused by *eg*, accident, struck by lightning, drowning, suicide, or death cause by person or persons unknown as a result of lawful or unlawful intentional and or unintentional act culminating in unforeseeable death), death caused by act of God, death caused by natural causes and open verdicts. As for the latter verdict, where there is insufficient evidence to bring in any verdicts, then open verdict must be adverted to.

[33] And we can see how the above-said flow was adopted by Mah Weng Kwai JCA (as he then was) in the same case of *Teoh Meng Kee v. PP* (*supra*). His Lordship (as he then was) firstly considered a verdict of misadventure but then ruled it out simply because there was no evidence whatsoever to suggest that Teoh Beng Hock had accidentally fallen out of the window on the 14th floor of the MACC office. Then, His Lordship (as he then was) went on to consider the verdict of suicide. But the verdict was later discounted too because there was no evidence to show that the deceased would have been driven into a state of mind to want to kill himself to end everything. Finally, the verdict was one of death caused by person or persons unknown was returned. And this was made based on the proved facts before the court.

[34] In *Re Rumie Mahlie, Deceased* [2007] 10 CLJ 697, an open verdict was delivered by the learned Magistrate. This is the verdict:

> I am therefore of the opinion that the deceased's death occurred between 10.50 - 10.59 am on the 17 September 2004. It occurred on the ground floor of the STA building. The deceased died due to multiple injuries within his body which affect his main internal organs secondary from fall from height. With regard to the manner in whichthe deceased came to his death, the court cannot determine based on the depositions before it whether his death resulted in any way from, or was accelerated by any unlawful act or omission on the part of any person.

[35] What the case of *Re Rumie Mahlie*, *Deceased*'s case emphasises is the important duty of a Magistrate or Coroner to make a definite finding based on the proved facts produced and not on mere conjectures.

Court's Finding

[36] Having the clear principles in mind, I now set out and discuss the facts and evidence chronologically.

[37] The issue before this court to determine whether the "open verdict" made by the Coroner may be sustained based on the facts dan evidence submitted before me in accordance with s. 377 of the Criminal Procedure Code and Practice Direction of the Chief Justice No. 2 of 2019.

[38] The Coroner proceeded in stating the facts from witnesses SI-1 to SI-30 as follows:

(i) the deceased underwent a health examination and was affirmed to be medically fit;

(ii) due to his medical fitness, the deceased was accepted to join training as a navy recruit;

(iii) on 12 May 2018, the deceased and others reported duty at KDS11 to undergo navy training;

(iv) the deceased participated in supervised physical training according to schedule;

(v) the deceased was seen unable to cope or keep up with other trainees for the physical training exercises;

(vi) the deceased seemed tired and wanted to "lapor sakit";

(vii) some witnesses testified the deceased did not "lapor sakit";

(viii) some witnesses testified the deceased wanted to "lapor sakit" but was denied;

(ix) some witnesses testified the deceased was punished with extra training;

(x) some witnesses testified there was no such punishment imposed;

(xi) there were bruises, injuries and abrasions on the deceased person's body;

(xii) there were other trainees who did not complete training and left the navy due to medical conditions;

(xiii) the trainees were instructed to relocate to other building as there was suspicion of contaminated water at the previous living quarters; and

(xiv) there was suspicion of leptospirosis.

[39] In our present case, the Coroner issued an "open verdict" after inquiring into the case on the following findings of facts:

(i) on injuries, bruises, abraisons on the body of the deceased, witnesses testified that those were normal due to navy training, and all other trainees have the same injuries and/or abrasions, depending on the type of training;

(ii) on extra training as punishment, it was submitted by the counsel for family of the deceased that witnesses who were still serving in the navy were warned to not speak the truth, thus testified there was no such punishment whereas witnesses who left the navy spoke the truth that

there was such punishment imposed on the deceased. This court took all evidences, except on the allegation of not speaking the truth, as all witnesses took an oath to speak the truth in open court;

(iii) on leptospirosis and rhabdomyolisis, there was no evidence of such existence but mere suspicion;

(iv) on denial to "lapor sakit", the two "lapor sakit" sheet, D16(1)-(2) found by SI-29, although filled, were not proof that the sheet were actually referred to PLB, thus could not be said to have been denied;

(v) on SI-1's competency to perform post-mortem, this court found that SI-1 was a competent medical officer who completed the post-mortem to come up with the correct cause of death as agreed by the expert forensic pathologist SI-30, although SI-1 could have done more examinations as suggested bt SI-30; and

(vi) all trainees went though the same physical training and all trainees and officers at KDS11 had the same water supply.

[40] The Coroner in inquiring into cause of death of the decased under s. 337 of CPC, has made the determination on the following questions:

(i) who – identity of the deceased

the deceased was Soosaimanickam a/l Joseph (deceased) a trainee cadet officer (PKG) Siri 26/18 at KD Sultan Idris 1 ("KDSI 1"), Pengkalan TLDM, Lumut Perak. At the time of death, he was 26 years nine months 19 days of age.

(ii) how the deceased died

here the Coroner did not make a straightforward determination. Instead, the Coroner went at some length into the facts of the case as clearly stated above at para. 39;

(iii) when the deceased passed away

the deceased passed away on 19 May 2018 at 1.45 in the noon.

(iv) where the deceased passed away

the deceased passed away at Hospital Angkatan Tentera (HAT)

(v) cause and manner of death; pulmonary oedema

(vi) whether any person is criminally liable in the cause of the death of the deceased?

As to whether there was any person involved in the deceased's death, this court rules in the negative. Therefore, the verdict in this inquest is open.

A **[41]** The Coroner's verdict is being challenged as erroneous in law and facts by the appellant's counsel. Now, it is the duty of this court at appeal stage to review all the evidence in totality. Speculations and probabilities are not acceptable bases for a verdict.

B **[42]** The Coroner was excessively concerned of certain evidence that were not presented at the inquest, which she believed created a gap in the evidence chain. This concern according to her led her to issue an 'open verdict'.

[43] I will now analyse the Coroner's findings that led to her issuing the 'open verdict'.

C **[44]** The issues that give rise to this appeal are with regards to the Coroner's determination regarding the cause of death and the manner by which the deceased passed away, which is directly linked to the conclusion of the criminally liable in the cause of the death of the deceased.

D **[45]** Based on the evidence, it is undisputed evidence that before the deceased attended the cadet training, he was a healthy individual without any underlying health condition (see the medical reports exhibited at pp. 181 to 185 of Rekod Rayuan Jilid 3(A), Laporan Pemeriksaan Kesihatan Kemasukan Perkhidmatan at pp. 119 to 124 and Laporan Pemeriksaan Berkala at pp. 130 to 134 of Rekod Rayuan Jilid 3(A)). Both the E abovementioned health examinations gave the deceased a clear bill of health that allowed him to undergo the cadet training.

[46] Thus, how could a healthy 27-year-old boy have died only after a week of training? Based on a post mortem conducted by SI-1, the ensuing postmortem report only concluded the cause of death to be pulmonary F oedema. There was no explanation on how the deceased as a healthy individual could have suddenly died by pulmonary oedema (see the post mortem reports exhibited at pp. 13 to 16 of Rekod Rayuan Jilid 3(A)). No doubt, a later supplementary postmortem report was issued stating that there were features of lung infection found. Yet, it failed to identify the source of G infection and the cause of death remained to be pulmonary oedema. I believe pulmonary oedema cannot be stated as the cause of death of the deceased.

[47] The Coroner summarily dismissed SI-30's expert testimony without any cogent grounds. I believe that it is crucial to properly consider the testimony of SI-30 who is a renowned Forensic Pathologist with extensive H experience in the field (see SI-30's CV at pp. 186 to 195 of the Rekod Rayuan Tambahan Jilid 3(A)). I am of the same view with SI-30 that the post-mortem should have been conducted by a trained Forensic Pathologist. As follows reproduced the examination of SI-30 (see p. 545 of Rekod Rayuan Jilid 1(C)):

I Q: What was your findings in this case?

A: … in a institutional death like this especially the government agencies, the post mortem should have been conducted by a Trained Forensic Pathologist, especially cause of death like in this case was not obvious.

[48] Therefore, based on the evidence above, it was argued by learned counsel that SI-1 is not an expert Forensic Pathologist, but only a medical officer (see SI-1's CV at pp. 11 to 12).

[49] Whether pulmonary oedema alone can be the cause of death? Based on SI-30 testimony at pp. 545 to 547 of Rekod Rayuan Jilid 1(C), which in summary are:

(i) failure to send blood and urine samples for examination;

(ii) failure to conduct tissue dissections of the liver, kidneys and other organs;

(iii) no subcutaneous dissection of the tissues were taken to look for any bruises in the subcutaneous tissue;

(iv) failure to conduct a more detailed examination of the heart and lung tissues; and

(v) failure to quantify the ophenadrine that was recovered from the body.

[50] Thus, due to the crucial gaps in the post-mortem report which fails to disclose the proper cause of death of the deceased, SI-30's expert evidence must be properly considered. As follows reproduced the examination of SI-30 (see p. 545 of Rekod Rayuan Jilid 1(C)):

Q: What was your findings in this case?

A: ...The cause of death of Pulmonary Oedema was not appropriate as it is just a finding in this particular case. What lead to the Pulmonary Oedema is what we are interested in.

[51] This court is of the view that pulmonary oedema alone as the cause of death is insufficient as it does not explain how the pulmonary oedema occurred to begin with.

[52] Further, it was SI-30's learned opinion that the symptoms leading to the death of the deceased is consistent with leptospirosis. As follows reproduced the examination of SI-30 (see p. 546 of Rekod Rayuan Jilid 1(C)):

Q: What was your findings in this case?

A: … From the available history, the patient has been complaining about difficulty in breathing and muscle aches. And with a positive find of pulmonary haemorrhage, muscle aches and also difficulty in breathing and with known history of some participants lodging with the patient who also developed renal and the deceased also has deranged. Liver enzymes, all these are suggestive of the deceased

A probably having leptospirosis from the beginning. Not being treated, the deceased went into massive renal failure, shock and massive pulmonary haemorrhage.

[53] SI-30 also went further and stated that it is also likely that the deceased contracted the disease when he was in KDSI 1. (examination of SI-30, see B p. 548 of Rekod Rayuan Jilid 1(C)):

Q: Based on facts, 12.5.2018 training and died 19.5.2018. Is it likely that he got disease during or prior to training?.

A: He was infected in the institution when he started tarining because disease progress 4-5 days. Then if he was exposed to the C contaminated water, safe to say he got infected during that period.

[54] This court found that the cause of death being leptospirosis is supported by the evidence of an expert by of SI-30 upon examination of all available documents relating to the post-mortem, the deceased medical history and the "Ulasan Pegawai Kesihatan Daerah Manjung", "Laporan D Kejadian Kluster Acute Respiratory Syndrome Probably Secondary to Leptospirosis", all of which serves to prove his conclusion to the cause of death.

[55] The evidence of SI-30 as an expert must be given due weight, E especially as it is clear that his opinion was given consideration of all the evidence above. In the case *Dr Shanmuganathan v. Periasamy Sithambaram Pillai*, where the Federal Court held that:

The learned judge should have considered the reasoning given by the expert and with that assistance arrived at the conclusion. In failing to do F so the learned judge had abdicated his function. The learned judge is entitled to reject the evindence but not before considering such evidence. The evidence of the expert is admissible and relevant to the fact in issue properly placed before the learned judge. The learned judge ought to consider all such evidence that is before him prior to arriving at a finding on the issue. Only after such due consideration been given could he come G to a finding.

[56] Further reference is also made to the decision of the Court of Appeal in the case of *Majuikan Sdn Bhd v. Barclays Bank Plc* [2014] 9 CLJ 337; [2015] 1 MLJ 171 which states:

H [35] We are in agreement with these principles and in our view, a judge who is not an expert himself, should defer to expert opinion unless that evidence is obviously indefensible and is not supported by the basic facts of the case. Where there are conflicting expert opinions, the judge is of course entitled to bring to bear his own judicial appreciation of the matter, and choose one over the other, but where there is only one expert I opinion, he should not as a rule reject that opinion outright without judiciously considering whether it is obviously indefensible and unsupported by the basic facts of the case.

[57] The Coroner summarily dismissed SI-30's expert testimony without any cogent grounds, which is contrary to established principles applicable when assessing such evidence in the case of *Dr Lo Sook Ling Adela v. Au Mei Yin Christina & Anor* [2002] 1 SLR 408:

> In law, while a judge is not obliged to accept the opinion of an expert, even in a situation where there is no contrary expert evidence, such rejection must be based on sound grounds.

[58] Therefore, this court have accepted the findings of SI-30 and stated the cause of he death to be pulmonary oedema caused by leptospirosis.

[59] Now, for this court to determine whether the death of the deceased was caused by failure to give medical treatment and or the TLDM's officers in charge of the cadet training at KDSI 1 in denying the deceased to seek medical treatment.

[60] Based on the evidence, both SI-1 and SI-30 agreed that had the deceased been treated earlier, then the deceased could have likely survived. As follows reproduced all the relevants questions from Rekod Rayuan Jilid 1(A) between pp. 25 to 26 and Rekod Rayuan Jilid 1(C) between p. 548 as follows:

> Examination of SI-1
>
> Q: Dalam keadaan in yer Dr, keadaan yang Dr describe. There are any treatment available?
>
> A: Yes, there are treatment available, but it is, kalau dia mengalami demam, perlu dirawat secara intensive dan cepat benda ini, kalau paru-paru berair, kita kena bagi pertolongan pernafasan, seperti bagi oksigen. Kalau disebabkan oleh jangkitan kita kena start antibiotic treatment dan perlu diwadkan dan diobserve. Perlu mengambil treatment di hospital.
>
> Q: Tapi ada treatment lah?
>
> A: Ada.
>
> Q: Boleh dirawat secara total?
>
> A: Boleh.
>
> Examination of SI-30
>
> Q: What was your findings in this case?
>
> A: … in my opinion if the deceased had been referred to medical institution early, recovery would have been helpful.

[61] The next question is why the deceased was not given treatment earlier? It is crucial for the Coroner to determine whether the deceased was denied medical treatment by the TLDM officers whilst he was undergoing the PKG training before his untimely death.

[62] Based on the brother of the deceased, SI-29 whereby he produced two "lapor sakit" sheets (see pp. 135 to 138 of Rekod Rayuan Jilid 3(A)) that were partially filled up by the deceased, which shows that the deceased had intentions to seek medical treatment. Thus, the two "lapor sakit" sheets directly contradicts any evidence that the deceased did not attempt to seek medical treatment.

[63] Furthermore, it in fact corroborates the testimony that there is a denial of treatment of the deceased as attested to by SI-24, SI-25 and SI-27. As follows the court reproduced all the relevants questions from Rekod Rayuan Jilid 1 (C), between pp. 500 and 512 as follows:

Examination of SI-24

Q: Adakah si mati maklum keadaan dia kepada kamu?

A: Dia akan complain kaki dia sakit, susah bernafas, kakinya lambat. Saya suggest minta bantuan officer pergi HAT. Waktu dia buat request, dia di reject can saya cuba delay masa di dipanggil oleh pegawai untuk masuk baris sebab dia penat dan sakit. Saya inform pegawai untuk check si mati dan bilik dia tapi my request ignored.

Examination of SI-25

Q: Bagaimana keadaan Soosaimanicckam hari demi hari?

A: Dia tidak dapat follow, sukar bernafas, tercungap. Tidak dapat naik tangga, lemah. Itu sahaja pemerhatian fizikal saya terhadap dia. Semasa saya sapu ubat, dia kata ada hendak berhenti. Saya tanya kenapa tidak lapor sakit, dia bagitahu sudah tapi tidak dibenarkan, saya kata cuba lagi lah, dia kata tidak dapat lagi lah.

Examination of SI-27

Q: Bagaimana keadaan kesihatan si mati dari hari pertama hingga di meninggal?.

A: Saya bersembang dengan dia juga, kesihatan dia menurun dan ada satu hari, tidak ingat bila, kalau tak salah, Rabu, saya dengan dia kumpul untuk lapor sakit di HAT, kumpul di Mahkamah Tentera. Masa tengah berkumpul, Leftenan Komander Faiz datang dia tanya siapa sakit, sampai dekat Soosaimanicckam, dia cakap, kau lagi? Kemudian dia tidak terima alasan kami dan arah kami tukar pakaian latihan pagi, kemudian masa saya balik, Leftenan Komander Faiz panggil saya balik dan beri kebenaran saya untuk ke HAT. Tapi Soosaimanicckam tidak dibenarkan. Masa beratur, Soosaimanicckam tanya saya kenapa hendak pergi ke HAT? Saya kata sakit kaki. Saya tanya Soosaimanicckam kenapa dia hendak pergi HAT dan Soosaimanicckam bagitahu tangan dia luka, kepala dia darah dan dia susah hendak nafas.

[64] This court was compounded by the fact that all witnesses had agreed that the deceased was having difficulty completing physical training, which points to a deteriorating physical state and there were no reasonable grounds

given by the Coroner as to why she preferred and accepted the testimonies stating that the deceased did not seek treatment over the testimonies of SI-24, SI-25 and SI-27 and the two "lapor sakit" sheets.

[65] In the case of *ING Insurance Bhd v. Rathinasamy Kasinathan* [2018] 10 CLJ 488; [2018] 2 MLJ 369 where the Court of Appeal held:

> [62] It is of course an established principle that faced with two conflicting versions before ger, the learned trail judge, as a primary trier of facts, was perfectly entitled to accept one version as opposed to the other version. *However, any acceptance or rejection of one version over the other must be based on a proper evaluation and weighing of the entire body of evidence before her of both parties.*
>
> [63] *Indeed, when presented with two conflicting evidence by parties, it is incumbent upon the learned tria judge to undertake a critical evaluation of the sworn evidence which she had admitted including contemporaneous documentary evidence to see which version is inherently probable or improbable.*
>
> (emphasis added)

[66] Therefore, the death of the deceased was caused by leptospirosis which went untreated because of the unlawful refusal by TLDM officers to allow him to seek medical treatment.

Conclusion

[67] Considering all the evidence before the inquest and Coroner's limited judicial appreciation of them, this court therefore set aside the findings of the "open verdict" of the learned Coroner and substitute with "homicide" that the cause of death of the deceased is pulmonary oedema caused by leptospirosis, and that his untimely death is a direct consequence of the Malaysian Royal Navy ("TLDM") officers in charge of the cadet training in denying the deceased to seek medical treatment pursuant to para. (d) of the Chief Justice's Direction No. 2 and pursuant to s. 337 of the CPC to decide who is the person criminally concerned in the cause of death.

[68] With greatest of respect to the learned Coroner, she took the easy way out of coming to an "open verdict" without considering the evidence before her.